DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: UT-01-018

2. STATE: UTAH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 413.85

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 12,000,000
b. FFY 2003 $ 12,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-A, PAGE 17

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~SAME~~ NEW

10. SUBJECT OF AMENDMENT:
GRADUATE MEDICAL EDUCATION

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Rod Betit

13. TYPED NAME:
ROD L. BETIT

14. TITLE:
EXECUTIVE DIRECTOR
DEPARTMENT OF HEALTH

15. DATE SUBMITTED:
SEPTEMBER 11, 2001

16. RETURN TO:
ROD L. BETIT, EXECUTIVE DIRECTOR
DEPARTMENT OF HEALTH
BOX 143102
SALT LAKE CITY, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
October 10, 2001

18. DATE APPROVED:
3/19/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCTOBER 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Mark Gilbert

21. TYPED NAME:
~~Spencer R. Erickson~~ Mark Gilbert

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS: The State (B. Goff) requested that I make the changes by Phone on 10/18/01 - Blk 4 - October 1, 2001, Blk 6-42 CFR 413.85, Blk 7 - FFY 2003 + FFY 2003, Blk 9-NEW

POSTMARK: October 5, 2001

FORM HCFA-179 (07-92)

Instructions on Back

INPATIENT HOSPITAL
Section 600 Health Profession Education

601 General – Utah Department of Health shall support the education of health professionals through the use of Medicaid funds. All hospitals eligible for health profession education payments will be identified through the use of Medicare cost reports. Specifically, worksheets E and S will be utilized to identify the participating facilities. Both fee-for-service (FFS) and health maintenance organization (HMO) services will qualify for health professional education payments. No distinction will be made between direct, indirect, or any other education payment. Payments, as defined below, will be made quarterly through the states Medicaid payment system.

602 Payment Pool– The payment pool is defined as appropriated state funds that will be used to draw down Federal Medical Assistant Program (FMAP). The annual payment pool will be determined prior to the beginning of each year on July 1st. The first year of this plan will begin 10-1-01 and adjusted accordingly.

603 Pool Distribution -- The pool will be distributed based upon the allocation percentage of each hospital. The hospital allocation percentage will be developed using prior year patient days (both HMO and FFS), and weighted intern and resident (I&R) full time equivalency (FTE). For example:

	(a) Weighted I&R FTEs	(b) Hospital Patient Days	(c) (a * b) Weighted FTE Days	(d) (c % of total c) Hospital Allocation Percentage	Payment Pool
Hospital A	256	32,414	8,297,984	68.22%	13,508,170
Hospital B	62	10,611	657,882	5.41%	1,070,957
Hospital C	150	21,381	3,207,150	26.37%	5,220,874
	468	64,406	12,163,016		19,800,000

604 Weighted FTE – The Utah Medical Education Council (UMEC) will determine annually the weighting factor for each resident specialty that will be applied to the I&R FTEs as reported by each participating hospital.

605 Upper Payment Limit – The aggregate Medicaid hospital payments, including health profession education payments, will not exceed the amount that would be paid for the services furnished under Medicare payment principles in compliance with the 42CFR447 upper payment limit.

TN No. 01-018
Date 03/19/02
Effective Date 10/01/01
Supersedes Transmittal NEW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: U T — 0 1 - 030

2. STATE: UTAH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 (a)(13)(A) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ -0-
b. FFY 2003 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-A, PAGES 1 through 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same, + Section 500

10. SUBJECT OF AMENDMENT:
Inpatient Hospital

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Rod Betit

13. TYPED NAME:
Rod L. Betit

14. TITLE:
Executive Director
Department of Health

15. DATE SUBMITTED:
December 24, 2001

16. RETURN TO:
Rod L. Betit, Executive Director
Department of Health
Box 143102
Salt Lake City, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
January 2, 2002

18. DATE APPROVED:
3/11/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCTOBER 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Mark Gilbert

21. TYPED NAME:
Mark Gilbert

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: unknown

FORM HCFA-179 (07-92)

Instructions on Back

UTAH STATE PLAN ATTACHMENT 4.19-A

INPATIENT HOSPITAL

INPATIENT HOSPITAL

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

INPATIENT HOSPITAL
Section 100 Payment Methodology

110 Introduction -- Under a Diagnostic Related Group (DRG) system, hospitals are paid a prospectively determined amount for each qualifying patient discharge. DRG weights are established to recognize the relative amount of resources consumed to treat a particular type of patient. The DRG classification scheme assigns each hospital patient to one of over 500 categories or DRGs based on the patient's diagnosis, age and sex, any surgical procedures performed, complicating conditions, and discharge status. Each DRG is assigned a weighting factor which reflects the quantity and type of hospital services generally needed to treat a patient with that condition. Preset prices are assigned to each DRG. The DRG system allows for outliers for those discharges that have significant variance from the norm. Each DRG has an outlier threshold 2.5 times its base DRG payment.

The DRG method of payment is used for inpatient services for Utah hospitals located in urban communities defined by the Standard Metropolitan Statistical Area (SMSA) and for out-of-state hospitals. In addition, Washington and Cache counties are included in the urban classification. Exceptions to the DRG payment system include (1) the State Psychiatric Hospital, (2) rural hospitals and (3) specialty hospitals, defined in Section 194. Rural hospitals are defined as Utah hospitals located outside of the SMSA. Rural hospitals are paid a negotiated percentage of allowable usual and customary charges.

120 DRGs General -- Except as otherwise provided, the federal DRG methodology definitions are adopted. The Utah Medicaid DRG system does have several unique features. The DRG Utah Weights and arithmetic mean average length of stay (ALOS) are extracted from Medicaid paid claims history files.

The methods for determining Utah Medicaid weights are explained in Section 121. Where insufficient Utah Medicaid history was available, the weights, arithmetic mean ALOS and threshold days were obtained from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), and, in some instances, newborn data from other states' Medicaid data. The HCFA data are published in the Federal Register.

HCFA data are adjusted to be compatible with the weights established with Utah Medicaid paid claims history. In the event HCFA adds new DRG categories, the state will also add those DRGs to be consistent with the certified HCFA DRG grouper tape. The methods used to establish the payment rates and outliers for non-psychiatric DRGs are discussed in Section 121.

The base Medicaid dollar multiplier factor is based on the FY 2000 expenditure history. The dollar multiplier factor is adjusted each year based on the negotiation of a factor for anticipated economic trends and conditions. By signing a provider contract, the hospital agrees to the

established payment rate. Furthermore, when economic conditions change during the year, the state may negotiate to change the terms of the contract including the payment rate with each hospital. Each hospital agrees to the DRG payment under a contractual agreement.

121 DRG Weights and Outliers -- The DRG weights are intended to reflect relative resource consumption. To establish DRG weights, data used were extracted from the Utah paid claims history files for a two-year period. Where the history did not contain a sufficient number of claims to adequately address the variance in charges and patient lengths of stay, HCFA weights, and ALOS were adjusted and used.

The Utah DRG weights were calculated from paid claims history data when there were more than 15 cases. The data base includes FY 1998 and FY 1999 paid claims history. Outliers were excluded in calculating the ALOS. Also, excluded were claims from rural hospitals. The geometric mean charge is calculated for each DRG. A statewide geometric mean charge for all cases is also calculated. The relative weight of each DRG is a function of the relationship between the geometric mean charge for each DRG and the geometric mean charge for all applicable DRGs. To determine the relative weight, the geometric mean charge for each DRG is divided by the statewide geometric mean charge per discharge.

The outlier payment threshold limit is 2.5 times the base DRG payment. Additional payments are paid for charges in excess of the threshold at the rate of 80 percent, adjusted by a case mix and hospital charge structure differential. A case mix index is calculated from the sum of Medicaid weights (excluding outliers) divided by hospital cases for each hospital. The case mix index is normalized. The normalized case mix index is adjusted for the average charge per case (hospital CMI adjusted charge per case), by hospital. The final adjustment factor is then calculated by dividing the hospital CMI adjusted charge per case by the statewide CMI adjusted charge per case.

There is a special calculation for DRGs 433 through 437 involving alcohol and drugs. Because the Medicaid scope of service is limited to detoxification, the payment rate for these DRGs is based on an average length of stay of three days.

122 Dollar Multiplier – There is a single dollar multiplier for all DRGs based on budget dollars available.

123 Effective Dates for Rates -- Payment rates will be effective based on "date of discharge." When a patient is transferred from another hospital, as opposed to discharged, the payment will be calculated using the rate in effect at the time of discharge.

130 Property and Education -- The Medicaid DRG payment rates are all inclusive. There are no designated pass-through costs or other add-on factors for costs such as capital, education or other expenditures. However, these factors are reflected in the hospital charge structure used to calculate the DRG payment.

140 Transfer Patients -- Except as otherwise specified in the State Plan, the federal Medicare methodology will be followed for transfer patients. The hospital which transfers the patient will be paid the DRG per diem fee for each day of care. The per diem is determined by calculating the DRG payment, dividing by the ALOS, and adding one day. Except as provided in the State Medicaid Plan, payment to the transferring hospital may not exceed the full prospective DRG payment rate. In cases of distinct rehabilitation units and hospitals excluded from the DRG prospective payment system, the transfers will be considered discharges and the full DRG payment, including outliers, will be paid. To be eligible for Medicaid payments, the exempt distinct rehabilitation unit must be part of an acute hospital. When a person is appropriately admitted and cared for in an acute hospital and is appropriately transferred to another hospital for extended specialized service and later transferred back to the first hospital, the first hospital is paid the full DRG for the combined stays while the other hospital is paid a per diem under the transfer payment policy. Such per diem payments are not restricted by the DRG payment limitation. Transfers involving hospitals excluded from DRGs will also be paid based on their respective payment methodology.

145 Split Eligibility -- When a Medicaid patient is eligible for only part of the hospital stay, the Medicaid payment will be calculated by the following formula:

> Claim Payment = Medicaid Eligible Days divided by Total Hospital Days x Full Medicaid Payment

The split eligible payment constitutes payment in full for all services rendered on those days on which the patient was eligible for Medicaid and must be accepted as such by the provider hospital. The hospital may not bill the patient for any services rendered on those days. In contrast, the hospital can bill the patient full charges for services rendered during those days that the patient is not eligible for Medicaid. When both third-party payments and split eligibility are involved, the third-party payment will first be applied to the period prior to eligibility. Any remaining TPL will be used to reduce the Medicaid payment.

160 Services Covered by DRG Payments -- Medicaid adopts the general provision of the bundling concepts used by Medicare. Physicians, including resident physicians and nurse anesthetists may bill separately under their own provider numbers. Such billings are in addition to the DRG payment. All other inpatient hospital services, as defined by Medicare, are covered by the DRG system. DRGs are paid for inpatient hospital admissions when a baby is delivered even though the mother or baby is discharged in less than 20 hours.

161 Donor Organs -- Medicaid adopts the general Medicare definitions to determine payment for approved donor organs. Medicare regulations and guidelines are used to establish payment amounts for donated organs.

162 Shaken Baby Syndrome Project – In accordance with a national initiative to educate parents to the dangers of shaken baby syndrome, Utah will participate in an educational effort

provided through hospitals. Payment for this educational effort is calculated at $6.00 per delivery in the state. Utah Medicaid will reimburse each DRG hospital $6.00 for all identified Medicaid deliveries (including Medicaid HMO deliveries). Payment will be made to each DRG hospital on a quarterly or annual basis based upon claims data. Rural hospitals receive payment for this project as a percentage of their charges.

165 DRG Determinations -- The Medicare DRG "grouper" software will be used for Medicaid. When changes are made, Utah Medicaid will adopt the changes within 31 days of the Medicare implementation date.

180 Utilization Review and Control of Inpatient Hospital Services -- Payment may be denied or withheld for inpatient hospital services which do not meet Medicaid regulations or criteria for medical necessity and appropriateness. Medicare regulations and guidelines apply when additional clarification or explanation is required. In the event payment is made and the services are subsequently deemed inappropriate or unnecessary, the payment(s) can be recovered through offsets to future payments. Payment may be denied or withheld in the following circumstances:

1. The inpatient care provided in an acute care facility is not medically necessary based on InterQual Criteria for inpatient admission.

2. The claim is based on an incorrect principal diagnosis.

3. The services or procedures requiring prior authorization have been provided without obtaining the appropriate prior authorization.

4. The patient is transferred when there is no medical justification. In the case of inappropriate transfers, the discharging hospital receives the full DRG and the transferring hospital is denied payment.

5. The patient has been readmitted within 30 days of discharge for the same or similar diagnosis. Except for cases related to pregnancy, neonatal jaundice, or chemotherapy, all re-admissions within 30 days of a previous discharge will be reviewed to ensure that Medicaid criteria have been met for: 1) severity of illness, 2) intensity of service, 3) appropriate discharge planning, and 4) financial impact to the State. Outlier days will be paid where appropriate. In addition, all claims are subject to post payment review.

Determinations of medical necessity and appropriateness will be made in accordance with, but not limited to, the following criteria and protocols:

1. The Diagnostic Related Group (DRG) system that was established to recognize the relative amount of resources consumed to treat a specific type of patient. The Utah

DRG weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files, where available, or from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA).

2. The comprehensive, clinically-based, patient-focused medical review criteria and system developed by InterQual, Inc.

3. The appropriate, Utah-specific Administrative Rules or criteria developed through the Utilization Review Committee for programs and services not otherwise addressed.

4. The determination, where deemed necessary, of the Utilization Review Committee. The Committee must include at least two physicians and two registered nurses. The Committee will review and make recommendation on complicated or questionable individual cases.

190 Exempt Hospitals -- Two categories of hospitals are exempt from DRGs:

The State Hospital will continue to be reimbursed per diem cost for each operating unit. The per diem is calculated using Medicare regulations to definite allowable costs. In applying cost reimbursement principles, the Utah State Hospital is required to capitalize only those assets costing more than $5,000.00 A separate per diem is calculated for each operating unit. Therapeutic leave days are included in the total count of Medicaid days, unless the patient was discharged. However, if a patient is admitted as an inpatient to a second hospital, the patient is deemed to be discharged from the State hospital and the days are not counted. The day count used in the Medicaid cost settlement must be consistently applied for all admissions for all classes and/or groups of patients. Because of their unique patient population, the Utah State Hospital is not part of the DRG system. Medicaid does not use the Medicare methodology to pay an average cost per discharge.

TEFRA limits do not apply because of long lengths of stay experienced by many of the patients.

Rural hospitals located in rural areas of the state are exempt from DRG. Medicare definition of "rural hospital" is adopted by Medicaid. Rural hospitals are paid 93 percent of charges.

194 Specialty Out-Of-State Hospitals -- These hospitals provide inpatient services that are not available in the State of Utah. To qualify for this special payment provision, prior authorization must be obtained from the Utah State Department of Health, Division of Health Care Financing. The payment amount will be established by direct negotiations for each approved patient. The DRG method may or may not be used depending on the negotiated payment. Typically, the Medicaid rate in the State where the hospital is located is paid.

196 Short Stays -- Generally, patients discharged from the hospitals in less than 24 hours are classified and billed as "outpatient." An exception to this policy involves maternity care. DRGs 370-375 and 388-391 cover deliveries and babies. These services are paid as inpatient services under the DRG system.

INPATIENT HOSPITAL
Section 200 Other Payments

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210 Small Volume Utah and Out-of-State Hospitals -- Except as provided in Section 190, payment will be made under the same DRG methodology as in-state urban hospitals.

240 Sub-acute Care and Swing-beds -- This policy pertains to patients that do not require acute hospital care.

- When sub-acute care patients receive medically necessary services in an inpatient hospital setting, payment is made at the swing-bed rate. Because sub-acute patients require a lower level of care, the rate is lower than the rate paid for acute hospital services. The sub-acute rate is calculated using the criteria specified in 42 CFR 447.280(a)(1).

- When nursing home beds are not immediately available in the community, patients may receive skilled or intermediate nursing care in a bed of a qualified hospital. Rural hospitals typically qualify for the swing-bed program. Payment is made at the swing-bed rate using the criteria specified in 42 CFR 447.280(a)(1). Patients are transferred to licensed nursing home beds in certified facilities when such beds are available in the community.

- Services provided in hospitals licensed as chronic disease or rehabilitation will be paid the nursing facility intensive skilled rate defined in Section 1000 of Attachment 4.19-D of the State Plan, as modified by this Section. Rehabilitation days of care require prior approval to qualify for payment. Intensive skilled rates are negotiated for individual patients. In determining the intensive skilled rates for hospital rehabilitation units, therapy costs are allowed to be included with nursing costs referenced in therapy costs are allowed to be included with nursing costs referenced in Attachment 4.19-D, Section 1000. In addition, the intensive skilled payment is limited to the amount Medicare would pay for the same services at the same facility.

241 Insignificant Billing Variances -- When the Medicaid payment is determined using the billed usual and customary charges (i.e., rural hospitals), insignificant billing errors may be processed. To expedite payment and to reduce administrative effort, Medicaid pays the lesser of the detailed charges or the total charges, if the difference is ten dollars or less.

250 Payment for Emergency Days -- Emergency days for inpatient psychiatric services cover the time between admission and the first service date authorized by the Medicaid prior authorization staff. Emergency days under the DRG system will be paid a per diem for each approved day. As with transfer patients, the DRG per diem will be calculated by dividing the DRG payment by the arithmetic mean length of stay.

251 Third-party Payment -- When insurance or other third-party payors have responsibility for payment, Medicaid is the payor of last resort. The amount paid by Medicaid is limited to the patient's liability. Further, Medicaid payment for specified Medicare crossover claims will be the lower of: (1) the allowed Medicaid payment rate less the amounts paid by Medicare and other payors, or (2) the Medicare co-insurance and deductibles.

252 Interim Payments -- There are two types of interim payments for DRG hospitals. First, hospital stays in excess of 90 days may be billed under the DRG system prior to discharge with prior approval. The interim bill is paid at 60% of the allowed charge. Second, an interim payment may be granted when the lag time between the date of service and the date of payment for a specific hospital is above the "mean" processing time for all DRG hospitals. In addition, the hospital requesting the interim payment must be able to document a cash flow problem that could impair patient care. The amount of the interim payment is based on the cash flow needs of the hospital not to exceed the Medicaid interim payment limit. The interim payment limit is calculated by multiplying the number of days above the "mean" processing time by the average daily Medicaid payment.

INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals

409 INTRODUCTION -- This section establishes criteria for identifying and paying disproportionate share hospitals (DSH). For the purpose of paying disproportionate share hospitals, there are five types of hospitals: First, private hospitals licensed as general acute hospitals located in urban counties; Second, general acute hospitals located in rural counties; Third, the State Psychiatric Hospital; Fourth, the State Teaching Hospital; and Fifth, Childrens' Hospitals.

410 DEFINITIONS- For purposes of this section, the following definitions apply:

A. Medicaid Inpatient Utilization Rate (MIUR) is the percentage derived by dividing Medicaid hospital Inpatient days (including Medicaid managed care inpatient days) by total inpatient days.

B. Low Income Utilization Rate (LIUR) is the percentage derived by dividing total Medicaid revenues (including Medicaid managed care revenues) plus UMAP revenues by total revenues and adding that percentage to the percentage derived from dividing total charges for charity care by total charges.

C. Indigent patient days is the total of Medicaid patient days (including managed care days) plus UMAP patient days and other documented charity care days.

D. UMAP is the Utah Medical Assistance plan operated for low income (indigent) recipients not eligible for Medicaid.

411 OBSTETRICAL SERVICES REQUIREMENT -- Hospitals offering non-emergency obstetrical services must have at least two obstetricians providing such services. For rural hospitals, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital. This requirement does not apply to children's hospitals nor to hospitals which did not offer non-emergency obstetrical services as of December 22, 1987.

412 MINIMUM UTILIZATION RATE — All DSH hospitals must maintain a minimum of 1% Medicaid patient utilization rate.

INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

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413 HOSPITALS DEEMED DISPROPORTIONATE SHARE -- A hospital is deemed a disproportionate share provider if, in addition to meeting the obstetrical (Section 411) and the minimum utilization rate requirements (Section 412), it meets at least one of the following five conditions:

A. The hospital's MIUR is at least one standard deviation above the mean MIUR. The disproportionate share computed percentage is based on the number of percentage points that an individual hospital indigent patient days exceeds the statewide average plus one standard deviation.

B. The hospital's LIUR rate exceeds 25 percent.

C. The hospital's MIUR exceeds 14 percent.

D. The hospitals UMAP participation is at least 10 percent of total hospital UMAP patient care charges.

E. Hospitals located in rural counties qualify because they are sole community hospitals. A sole community hospital is defined as a hospital that is located more than 29 miles from another hospital.

414 PAYMENT ADJUSTMENT FOR GENERAL ACUTE URBAN (excluding State Teaching Hospital and Childrens' Hospital) - - General Acute Urban Hospitals (Paid by DRGs) and meeting the qualifying DSH criteria are paid a DSH amount on each inpatient claim. The DSH Factor is derived by dividing the indigent inpatient days by the total general acute days for each hospital and multiplying by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting percentage (DSH Factor) is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor.

415 PAYMENT ADJUSTMENT FOR GENERAL ACUTE RURAL – General Acute Rural Hospitals are paid a DSH payment amount on each inpatient claim. The hospital must qualify based on the criteria shown in section 413 above. The DSH factor is derived by dividing the indigent patient days by the total general acute days for each hospital and multiplying by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting percentage (DSH factor) is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid payment times the DSH factor.

INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

416 PAYMENT ADJUSTMENT FOR STATE PSYCHIATRIC HOSPITAL -- The State Psychiatric Hospital is reimbursed on a retrospective annual cost settlement basis. Its DSH payment is calculated on the proportion of indigent patient days to total inpatient days. The indigent proportion is multiplied by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed Federal DSH limits. The result is the DSH factor which in turn is applied to the cost settlement amount. The DSH payment will necessarily be adjusted to reflect Federal DSH limit amounts. The DSH is paid as an interim payment during the year, with a final computation being completed with the settlement of the annual cost report.

416A CAPITALIZATION OF ASSETS -- In establishing allowable cost, the Utah State Hospital is required to capitalize only those assets costing more than $5,000.

417 PAYMENT ADJUSTMENT FOR STATE TEACHING HOSPITAL -- The hospital's DSH factor is the ratio of Indigent patient days to total patient days times a "ceiling factor. The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limit amounts. The resulting DSH factor is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor. The DSH payment amount will necessarily be adjusted to reflect federal DSH limits.

418 PAYMENT ADJUSTMENT FOR CHILDRENS' HOSPITAL -- The Childrens' hospital DSH factor will be computed as a separate category from other general acute hospitals. The DSH payment will necessarily be adjusted to reflect Federal DSH limit amounts. The hospital's DSH factor is the ratio of Indigent inpatient days to total inpatient days times a "ceiling factor". This DSH factor is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor. The DSH payment for this category of hospitals will have a base year of 1999, i.e., DSH payments will not be less than the amount paid under a previous hospital category (General Acute Urban), subject to Federal DSH limit adjustment.

INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

421 METHOD AND TIMING OF DSH PAYMENTS -- Each claim for payment to qualified providers includes a percentage add-on at the level specified for that facility. Each quarter the total amount of DSH to all qualified facilities is calculated. The amount, along with any preceding quarters for the current fiscal year, is used to predict the total amount that will be paid. If this exceeds the current DSH allotment, the payment level will be adjusted in order to correct for any potential overpayment. This adjustment will be applied to all hospitals proportionally, except for Childrens' hospital which will not be adjusted below the base year (see section 418).

INPATIENT HOSPITAL
Section 500 Inpatient Rehabilitation Services

501 General -- Because of the wide variation in the length of stay for rehabilitation services under DRG 462, there is a need to refine the DRG criteria. Rehabilitative services under DRG 462 are subdivided into five groups. Each group has an established average length of stay and a base payment calculated in accordance with Section 122 of Attachment 4.19-A. Payments are made for outliers above the designated threshold consistent with other DRG payments.

510 Designated Groups -- Rehabilitation is subdivided into the following groups: (1) Spinal -- Para; (2) Spinal -- Quad; (3) Head; (4) Stroke; and (5) Other. "Spinal -- Para" includes patients with paraplegia who require an initial intensive inpatient rehabilitation program. "Spinal -- Quad" includes patients with quadriplegia who require an initial intensive inpatient rehabilitation program. "Head" includes patients with head trauma and with documented neurological deficits who require an initial intensive inpatient rehabilitation program. "Stroke" includes patients

needing an initial intensive inpatient program because of disability due to a neurological deficit secondary to a recent cerebrovascular disease. "Other condition" includes patients with a neurological/neuromuscular disease or other disorder requiring intensive inpatient rehabilitation. The State Medicaid Agency requires prior approval of all classifications.

INPATIENT HOSPITAL
Section 600 Inpatient Medicaid DRG Refinement

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601 General – Due to the unique nature of Medicaid population, selected Medicare DRG have been refined and expanded into additional DRGs.

610 Neonate DRGs – Discharges under DRGs 385, 386, and 387 for neonate DRGs are broken out as follows:

DRG	Description
850	DRG 385 - NEONATE XFERED OR EXPIRED (Died <=1 day)
851	DRG 385 - NEONATE XFERED OR EXPIRED (Died >= 2 days)
852	DRG 385 - NEONATE XFERED OR EXPIRED (Transferred <= 10 days)
853	DRG 385 - NEONATE XFERED OR EXPIRED (Transferred >= 11 days)
860	DRG 386 - NEONATE EXTREM IMMATUR/RDS < 500 grams
861	DRG 396 - NEONATE EXTREM IMMATUR/RDS - 500 to 749 grams
862	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 750 to 999 grams
863	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 1000 to 1199 grams
864	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 1250 to 1499 grams
865	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 1500 to 1749 grams
866	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 1750 to 1999 grams
867	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 2000 to 2499 grams
868	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 2500 grams and over (with ICD9 Proc code = 9672)
869	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 2500 grams and over (w/o ICD9 Proc code = 9672)
880	DRG 387 - PREMATUIRE W/MAJ PROBLEMS - < 500 grams
881	DRG 387 - PREMATURE W/MAJ PROBLEMS - 500 to 749 grams
882	DRG 387 - PREMATURE W/MAJ PROBLEMS - 750 to 999 grams
883	DRG 387 - PREMATURE W/MAJ PROBLEMS - 1000 to 1199 grams
884	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 1250 to 1499 grams
885	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 1500 to 1749 grams
886	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 1750 to 1999 grams
887	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 2000 to 2499 grams
888	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 2500 grams and over

The fifth digit of ICD9-9-CM diagnosis codes 764 to 765 identifies birth weight. If no birth weight is provided in the medical record, the DRG with the highest birth weight will be paid.

620 – Psychiatric DRGs – Psychiatric DRGs are as follows:

DRG	Description
900	SCHIZOPHRENIA (UNDER AGE 13)
901	SCHIZOPHRENIA (OVER AGE 13)
902	PSYCHOSIS (UNDER AGE 13)
903	PSYCHOSIS (OVER AGE 13)
904	NEUROTIC DEPRESSION (UNDER AGE 13)
905	NEUROTIC DEPRESSION (OVER AGE 13)
906	ANXIETY (UNDER AGE 13)
907	ANXIETY (OVER AGE 13)
908	MISC. NEUROSIS (UNDER AGE 13)
909	MISC. NEUROSIS (OVER AGE 13)
910	PSYCHOPHYSIOLOGIC(UNDER AGE 13)
911	PSYCHOPHYSIOLOGIC (OVER AGE 13)
912	ADJUST. REACTIONS (UNDER AGE 13)
913	ADJUST. REACTIONS (OVER AGE 13)
914	MISC. DISORDERS (UNDER AGE 13)
915	MISC. DISORDERS (OVER AGE 13)

630 - Rehab DRGs – Rehabilitation DRGs are as follows:

DRG	Description
800	REHAB - SPINAL/PARA
801	REHAB - SPINAL/QUAD
802	REHAB - HEAD
803	REHAB - STROKE
804	REHAB - OTHER